STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515085	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows Center	723 Summers Street Parkersburg, WV 26101

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based upon record review and staff interviews the facility failed to report the results of investigations within approved time frames to the state survey agency(SSA). This was discovered during the Long term care survey process, during the review of Facility reported incidents (FRIs). This was found to be true for one (1) out of thirty (30) residents reviewed. Resident #74 and #108. Census: 92 Finding include: a) Resident #74 During record review of Facility reported incidents (FRIs) on 12/17/25, file with this FRI #242295 was missing the five day follow up. The initial report was received 01/06/25. This would make the five day needing to be submitted by 01/11/25 at 11:59 PM at the latest. There was no record of it anywhere in the file or of a attempt to transmit a copy to anyone that is required to be notified ie. Fax transmittal sheet or email attachment by that deadline time. The file only contained four (4) statements, none are dated or signed by anyone either interviewed or doing the interviewing. As well as two (2) Performance improvement plans (PiPs), both were non disciplinary in nature and only suggested counseling no correction or follow up noted. When talking with the Administrator on 12/17/25 at approximately 11:44 AM about FRIs missing information and he said he will do his best to get the items that are missing for me. He knew that there are a lot of issues with them from the previous administration and is working to do better on them since he has been over the facility. Not further items for this file were presented prior to surveyors exiting the building on the final survey day of 12/22/25. b) Resident #108A record review found an allegation of physical abuse reported on 06/05/25 Resident #108 reported that she never received a breakfast tray and someone shoved her by the shoulders. A review of an investigation revealed that there is no documentation that the incident was reported to all required state agencies. Subsequent review found an extension Request filed on 06/11/25. Continued review of the reportable found no witness statements from the employees or other residents residing in the facility that may have knowledge of the allegation. Subsequent review found no documented 5-day follow-up. During the interview on 12/22/25 at approximately 9:30 AM the Administrator verified that there were no documentation or statements from all staff working at the time or other residents that may have knowledge of the allegation. He stated that there was no other documentation to provide on the incident. He also verified they have been working on other complaints that was not investigated prior to him taking over as Interim Administrator.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	515085	A. Building B. Wing	12/22/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on resident interview, staff interview, and operation policy the facility failed to take actions to thoroughly investigate an alleged violation related to, abuse, neglect, exploitation or mistreatment, including injuries of unknown source, and take corrective action following the investigation. Resident identifier #1, #108, #109, #98, #74, #105, #104, and #102. Facility census: 92. Findings include: Record review of the facility's policy titled, Abuse Prohibition, showed: - The Administrator, or designee, is responsible for operationalizing policies and procedures that prohibit abuse, neglect, involuntary seclusion, injury of unknown source, exploitation, and misappropriation of property. The center must ensure that all staff are aware of reporting requirements and must support an environment in which covered individuals report a reasonable suspicion of a crime. - Immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect the administrator of designee will perform the following. - Report allegations involving abuse (physical, verbal, sexual, mental) not later than 2 hours after the allegation is made. - Report allegations to the appropriate state and local authority. - Initiate an investigation within 24 hours of an allegation of abuse that focuses on whether abuse or neglect occurred and to what extent. a) Resident #1 A record review found an allegation from an interview on 08/21/25 where Resident #1 with a Brief Interivew Mental Status (BIMS) score of 15 alleged neglect within the facility. A facility reported incident was completed 09/04/25 with action notes: Investigation has been initiated at this time. A statement dated 09/04/25 from Resident #1 revealed it was a follow up from her complaint on 08/21/25 where statements were made to a staff member with regards to being left soiled for four (4) hours. She stated that she soiled herself at 3:00 PM on 08/20/25 and was not assisted until 7:00 PM. She also stated that staff did not want to assist her with meals. A review of an investigation revealed that the issue was reported to required state agencies on 09/04/25. Continued review of the reportable found no witness statements from the employees or other residents residing in the facility that may have knowledge of the allegation. Subsequent review found a 5-day follow-up stating a body audit was completed, no injury noted. After investigation, it was found to be unsubstantiated due to inconsistency in the statements between resident and staff. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the interview on 12/22/25 at approximately 9:30 AM the Administrator verified that there were no documentation or statements from all staff working at the time or other residents that may have knowledge of the allegation. He also verified they have been working on other complaints that was not investigated prior to him taking over as Interim Administrator. b) Resident #35 A record review found an allegation of physical abuse reported on 06/05/25 Resident #35 reported that she never received a breakfast tray and someone shoved her by the shoulders. A review of an investigation revealed that there is no documentation that the incident was reported to all required state agencies. Subsequent review found an extension Request filed on 06/11/25. Continued review of the reportable found no witness statements from the employees or other residents residing in the facility that may have knowledge of the allegation. Subsequent review found no documented 5-day follow-up. During the interview on 12/22/25 at approximately 9:30 AM the Administrator verified that there were no documentation or statements from all staff working at the time or other residents that may have knowledge of the allegation. He stated that there was no other documentation to provide on the incident. He also verified they have been working on other complaints that was not investigated prior to him taking over as Interim Administrator. c) Resident #109 A record review found an allegation of sexual abuse reported on 12/09/24 Resident #109 reported that the night shift Charge Nurse touched her and she does not feel safe. A review of an investigation revealed that there is no documentation that the incident was reported to all required state agencies. Continued review of the reportable found no witness statements from the employees or other residents residing in the facility that may have knowledge of the allegation. Subsequent review found a five 5-day follow-up on 12/17/24 with no verification it was sent to required agencies. The conclusion stated that Resident #109 asked that the male charge nurse not provide care for her. During the interview on 12/22/25 at approximately 9:30 AM the Administrator verified that there were no documentation or statements from all staff working at the time or other residents that may have knowledge of the allegation. He also verified they have been working on other complaints that were not investigated prior to him taking over as Interim Administrator. d) Resident #98 (continued on next page)

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	515085	A. Building B. Wing	12/22/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/05/24, an initial reporting of an allegation of neglect regarding Resident #98 was reported to all required entities. The initial reporting stated as follows: Nursing assistant [NA] [#125] provided a statement on 11/2/2024 regarding the care of resident [#98]. He reported that a week and one half ago he noticed that [Resident #98] was developing a red spot on his tailbone. In his statement he reported telling the nurse [#154] that he thought the resident was developing a pressure sore. He reported after being off for a few days. He came back and when providing care to the resident, the area got worse and was starting to open. He again reported to the nurse [#154] about the area. The nurse told [NA #125] she would look at it later. [NA #125] told her again at shift change and her response was to look at it the next day. [NA #125] reported the next day he asked her if she had looked at the area. Her response was not yet and that she would. [NA #125] reported telling one of the other nurses on night shift that way they knew. Every time [NA #125] mentioned it to the nurse [#154] she did nothing about it. The allegation was thoroughly investigated and interviews were obtained. An unsigned investigative note concluded I feel as this was a communication mishap and technology error causing this event. The note stated an order for wound treatment had been entered, but the order did not carry over to the Treatment Administration Record (TAR) for nursing staff to complete the order. The corrective action was educate nursing staff regarding turning and repositioning. On 12/18/25 at 11:02 AM, the Director of Nursing confirmed the corrective action to educate nursing staff regarding turning and repositioning did not address the communication and technology errors that had occurred regarding Resident #98's pressure ulcer. No further information was provided through the completion of the survey process. e) Resident #74 During a record review on 12/17/25, the incident involving Resident #74 that was initially filed 01/06/25 showed multiple missing items that were required to be sent in as well as maintained in the records for each incident reported. The review revealed the initial report and five (5) day follow-up were missing. The file contained four (4) statements with handwritten names on top, none are dated or signed by anyone involved. Neither who was interviewed nor who did the interview could be confirmed by reviewing the statements. It also had two (2) performance improvement plans, noted to only be counseling with no follow-up. On 12/17/25 at approximately 11:44 AM spoke with administrator about the missing information and they said, I will do his best to get the items that are missing to me. No further information was provided prior to exiting the facility on 12/22/25. f) Resident #105 (continued on next page)

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	515085	A. Building B. Wing	12/22/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Incident with Resident #105 that Initially was reported on 08/07/25. It showed the facility filed two (2) extensions, the first one on 8/15/25 stating more time was needed to complete the investigations, and then a second on 09/05/25 due to management changes. This delayed the investigation almost one month (30 days) from the time it took place. The facility did perform skin checks on Resident #105 on 08/12/25, with no issues of note. This was four (4) days after the incident occurred. No skin issues were noted prior or after in the chart. Interview with Resident #105 and others took place on 09/10/25. Due to the extensions delaying the facility from talking with residents for almost thirty (30) days after the incident took place the residents were unable to recall what took place and could not verify or un-verify the allegations. The five-day follow-up revealed the incident was unsubstantiated but showed no supporting documentation on how the facility came to this conclusion, or what was done to correct the issue and prevent future occurrences form happening again. When interviewing the administrator on 12/17/25 at approximately 9:45 AM they stated, I walked into all these, and I know some were not done to the best of their ability. We are working to do a better job and ensuring all investigations are done to the best possible standard. g) Resident #104 During an audit of the Facility reported incidents (FRIs) conducted on 12/16/25 it was revealed that the facility did not take all necessary action to come to a complete conclusion and/or create a plan of action to prevent these events from occurring again. Statements were taken from multiple people, both residents and staff. These were deemed inconclusive by the facility, due to them containing conflicting information. There were no secondary interviews conducted, no follow ups to clarify discrepancies and/or verify statements given. Documentation was missing dates, times and signatures of people involved. Twenty-one (21) statements were taken, and all were missing from these pieces of information. They were all just stamped with a [NAME and TITLE] stamp on a line. The documents all contained four questions of a yes or no (closed ended) type and no follow ups asked. A five-day follow-up was completed and in file dated 10/10/25 stating a call light audit would be completed for seven (7) days and then randomly thereafter. There was no record of this being done in the file nor could it be produced when asked. During an interview with the administrator on 12/16/25 at approximately 4:12 PM they stated that they do not have a way to perform a call light audit on the system they have, but they did do manual ones as needed. The administrator was unsure if they had copies of them placed in the files. This was later confirmed that they were not in the files and copies could not be located the for this surveyor. No other information was contained in the file or presented prior to the exit on 12/22/26. h) Resident #102 (continued on next page)

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	515085	A. Building B. Wing	12/22/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/04/25, Resident #102 reported she was left soiled for an extended period of time. The resident had capacity to make medical decisions. She had a Brief Interview for Mental Status (BIMS) score of 15, indicating that she was cognitively intact. An investigation was initiated. Skin checks were completed for residents with a BIMS score of seven (7) and below with no new occurrences noted. Residents with a BIMS score of eight (8) and higher were interviewed. Staff interviews were conducted as well. After investigation, the facility found their investigation to be inconclusive due to conflicting statements. IDT team determined to do a call light audit for seven (7) days then random times after to ensure call lights are answered timely. During record review, on 12/22/25 at 9:30 AM, there was no evidence that the facility had asked Resident #102 anything other than the three (3) written yes or no questions that were asked of all residents with a BIMS of eight (8) or higher: On 10/04/25, did staff leave you wet for extended periods of time? On 10/04/25, did you receive your medication in a timely manner? On 10/04/25, did you receive fresh ice water? Resident #102 was known to be cognitively intact and may have been able to identify the staff member assigned to her care on the day in question. Additionally, the resident may have been able to provide more context about how long her call light was on before being answered and if her needs had been addressed at that time. Review of the facility's call light audit for seven (7) days revealed the following dates and times: 10/10/25 at 10:00 AM 10/11/25 at 12:00 PM 10/12/25 at 1:05 PM 10/13/25 at 9:00 AM 10/14/25 at 8:00 AM 10/15/25 at 2:00 PM 10/16/25 at 5:00 PM There was no evidence additional call light audits at random times were completed as per the facility's corrective actions listed in their five (5) day follow-up. During an interview on 12/22/25 at 10:20 AM, the Surveyor pointed out: (continued on next page)

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	515085	A. Building B. Wing	12/22/2025

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff had specifically asked Yes or No questions but did not supply more information in the written narrative if a resident responded with a yes. Staff had narrowed the date of ever being left wet for extended periods of time to only 10/04/25. This questioning would not have afforded a resident to answer in the affirmative if they had been left wet and unattended on a different day. Staff had completed the call light audits on day shift hours only. This would not have ensured the call lights were being answered timely at other times of the day or throughout the night. There was no evidence found during the record review that the facility had completed additional call light audits at random times as per the facility's corrective actions listed in their five (5) day follow-up. The Administrator remained silent and made no comment.

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	515085	A. Building B. Wing	12/22/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, resident, and staff interview. The facility failed to assist dependent Residents with activities of daily living (ADL's) in accordance with the resident's assessed needs for care. This is true for three (3) of eight (8) residents reviewed for ADL's care. Resident Identifiers: #30, #49 and #72. Facility census: 92. Findings Included:a) Resident #49 On 12/15/23 at 11:28 AM Resident #49 stated that she does not get showers or baths as ordered or her preference. She stated that she is supposed to get two showers a week. She continued to state that the staff say they don't have enough staff to give her a shower. A review of Resident #49's ADL documentation found only two (2) showers on 11/21/25 and 12/09/25 also noted seven bed baths noted in 30 days. No Refusals noted.During an Interview on 12/17/23 at 10:30AM the Director of Nursing (DON) verified there was no documentation that Resident #49 received showers as scheduled. b) Resident #30Observation on 12/15/25 at 12:23 PM of Resident #30 found his hair appeared oily, dirty and uncombed.During an interview 12/15/25 at 12:23 PM, Resident #30 stated that he does not get very many showers. Subsequent Observation on 12/17/25 8:45 AM found that his hair still appeared oily, dirty and uncombed. A review of Resident #30's ADL documentation found only one (1) shower on 12/02/25 and four (4) bed baths noted in 30 days. No refusals were noted. During an Interview on 12/17/23 at 10:30AM the Director of Nursing (DON) verified there was no documentation that Resident #30 received showers as scheduled. c) Resident #72 During an interview 12/16/25 at 11:12 AM, Resident #72s medical power of attorney (MPOA) stated that the resident does not get showers. She continued to say that the staff tell her that Resident #30 does not like to get up, so they just do bed baths. She stated that her mom needed her showers and always preferred to get a shower and to be clean. A review of Resident #72's ADL documentation found only two (2) showers on 11/29/25 and 12/12/25 also eight (8) bed baths noted in 30 days. No refusals noted. During an Interview on 12/17/23 at 10:30 AM the Director of Nursing (DON) verified there was no documentation that Resident #72 received showers as scheduled.

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	515085	A. Building B. Wing	12/22/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to assess and treat pressure ulcers within accepted standards of care. This deficient practice had the potential to affect one (1) of five (5) residents reviewed for the care area of pressure ulcers. Resident Identifier: #98. Facility census: 92. Findings included: a) Resident #98The facility's policy titled Skin Integrity and Wound Management with effective date 07/01/01 and revision date 09/15/25 stated wound evaluations would be performed for new in-house acquired wounds. The resident was admitted to the facility on [DATE] and was receiving hospice services. On 10/31/25, a nurse practitioner note stated, in part, Resident does have a stage II pressure ulcer to sacrum. No sign of infection noted .Pressure ulcer of sacral region, stage 2. Continue to cleanse with wound cleanser. Pat dry. Apply Sure Prep to periwound and under adhesive contact areas. Cover with Optifoam Gentle every 3 days and as needed. Will monitor and manage as appropriate.The following order was written on 10/31/24, Cleanse sacrum with wound cleanser. Pat dry. Apply Sure Prep to periwound and under adhesive contact areas. Cover with Optifoam gentle every 3 days and PRN. Neither Resident #98's Treatment Administration Records (TARs) nor Medication Administration Records (MARs) for October and November 2024 included this order. On 11/02/24 a skin check was performed which stated, in part, New skin Issue. Location: Coccyx. Issue type: Pressure ulcer / injury. Pressure ulcer staging: Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis. Wound acquired in-house. Wound is new. Signs and symptoms of infection: None. Length (cm): 5.9 Width (cm): 4.6 Depth (cm): 0 Area (cm2): 14.1 Undermining: No. Tunneling: No. Cleansing solution: Generic wound cleanser. Primary dressing: Foam. This was the first full assessment in the medical records of the coccyx pressure ulcer identified on 10/31/24.The 11/02/24 skin check also identified a new deep tissue injury to the right heel and a new blister to the left scapula. The following orders were written on 11/02/24: Cleanse area to right heel with wound cleanser and apply skin prep cover with foam dressing check every shift, change every three (3) days and as needed.Heel boots to be worn bilaterally to prevent further skin breakdown and release pressure. Check every shift and as needed. Neither of these orders were included on the resident's TAR or MAR for November 2024. Resident #98 passed away on 11/07/24. On 12/18/25 at 11:02 AM, the Director of Nursing (DON) confirmed a full assessment of the resident's coccyx pressure ulcer was not documented at the time of discovery on 10/31/24. She stated the assessment on 11/02/24 was the first documented full assessment of the pressure ulcer. The DON also confirmed the orders for treatment to the coccyx pressure ulcer and the heel pressure ulcer and for heel boots were not included on the TAR or MAR. She provided no documented evidence that the physician's orders regarding the dressing changes or application of the heel boots were followed. No further information was provided through the completion of the survey process.

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	515085	A. Building B. Wing	12/22/2025

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on food tray temperatures and resident interviews, the facility failed to serve food to residents that was palatable and at an appetizing temperature. Based on resident interview and staff interview, the facility failed to ensure hot foods were served hot and cold foods were served cold. This failed practice was true for four (4) of five (5) hallways tested for milk temperatures on the beverage carts and food tray temperatures for one (1) of one (1) meal trays tested throughout the survey process Facility census: 92.a) This surveyor asked the Director of Dining to temp the milk that was located on the west hall beverage cart on 12/15/25 at 12:45 PM. The temp was 54 degrees F. The Director of Dining acknowledged the temp was above the Food and Drug Administration (FDA) food code temp of 41 degrees F. On 12/17/25 at 12:15 PM the surveyor asked employee #152 for the temperatures of the lunch menu food items. He stated that the cook writes them on the production sheet. He then gave me a copy of the production sheet and stated that the cook did not write them down. 12/15/2025 at 12:00 PM , Resident #58 said, The food is terrible, they have not updated any meal preferences with me, I asked the manager almost (3) three months ago The food is cold, we are last to get meals sometimes they run out , I usually do not get what I ask for. When they send us food, generally it is all mixed together. 12/15/25 at 12:50PM , Resident #58's meal was served. Resident #58's meal was Turkeyburger, with lettuce, tomato and baked beans on plate, observation: baked beans running on plate under Hamburger Bun. Resident #58 informed this surveyor I wish they would have put those beans in a bowl. 12/15/25 1:30PM , Resident #58.Staff interview with Food Service Director, questioned her if she or anyone had updated Resident #58's meal preferences, she informed this surveyor, No I have not Spoke with Food Service Director (FSD), reviewed meal presentation for this lunch- she viewed the plate for Resident #58 and FSD confirmed the baked beans were running into the hamburger bun,

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	515085	A. Building B. Wing	12/22/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interview, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food safety. Additionally, the facility failed to follow the proper sanitation practices for the kitchen and the food preparation equipment. This practice had the potential to affect more than an isolated number of residents. Facility census: 92. Findings include: a) 12/16/25 8:30 AM during an observation of food delivery carts five (5) of five (5) each had food debris on the bottom shelves, outside of the cart along bottom of doors, and along outside of each cart was a dried substance. 12/16/25 9:00 AM during a staff interview, district manager for food and nutrition, reviewed the five (5) of five (5) food delivery carts and confirmed there was food debris on the bottom shelves, outside of the cart along bottom of doors, and along outside of each cart dried substance. On 12/15/25 at 11:40 AM the surveyor completed an initial walkthrough of the kitchen. The Director of Dining (DOD) accompanied the surveyor during and acknowledged the following findings to be accurate. The dish machine log was missing temperatures for two (2) meals. The toaster had debris and needed to be cleaned. One (1) box of food thickeners was open to air and did not have an open or use by date. One (1) trash can located near the preparation table with the can opener did not have a lid on it while not in use. The mixer bowl was not covered while not in use. The knife rack was soiled. One (1) block of margarine sitting on the countertop were open to air and was not dated properly. One (1) package of hamburger buns did not have an open date. The outside of the coffee maker was soiled. There was one (1) measuring cup of sugar open to air and not labeled or dated properly. The can opener was soiled. One (1) opened package of white cake mix with no open or use by date. Three (3) opened packages of grape drink mix without an open or use by date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515085	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willows Center	723 Summers Street Parkersburg, WV 26101

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	One (1) bowl of tossed salad not labeled or dated properly. Two (2) steam table pans with sliced and diced ham not labeled or dated properly. There was no liner in the trash can locate at the handwashing sink. There was no lid on the trash can located near the steam table while not in use. While the lunch meal is being served. Three (3) food storage containers were sitting directly on the floor under the prep sink. The meat slicer was not covered while not in use. The food storage container lids were wet nesting in a bussing bin. One (1) outdated container of tomato soup in the walk-in cooler dated for use by 12/14/25. One (1) container of cream of wheat in the walk-in cooler dated for use by 12/14/25. One (1) container of chicken & dumplings in the walk-in cooler dated for use by 12/12/25. One (1) container of ranch dressing in the walk-in cooler dated for use by 12/13/25. One (1) container of ricotta cheese in the walk-in cooler dated for use by 12/13/25. The fan cover in the walk-in cooler has debris present. Four (4) cases of frozen food sitting directly on the freezer floor. One (1) opened bag of chicken tenders in the freezer without an open or use by date. One (1) Ziploc bag of raisin toast located in the kitchen outdated with a use by date of 12/08/25. The ceiling vents located in the kitchen were dusty and rusty. This surveyor asked the Director of Dining to temp. the milk that was located on the west-hall beverage cart at 12:45 PM. The temp was 54 degrees F. The Director of Dining acknowledged the temp was above the FDA food code temp of 41 degrees F. One (1) gallon of whole milk outdated in the East / [NAME] nourishment room refrigerator with a use by date of 12/14/25. One (1) pint of whole milk outdated in the South nourishment room refrigerator with a sell by date of 11/21/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On12/26/25 at 8:38 AM two surveyors were accompanied by the Director of Dining outside to where the two (2) trash dumpsters were located. One of the sliding doors was not completely closed on one dumpster and the lids were not completely closed on the second dumpster. The Director of Dining stated the doors should be closed and are not. 12/17/25 at 8:55 AM This surveyor made a second visit to the kitchen. On 12/17/25 at 8:55 AM observation revealed the fan in the dish room was soiled with debris. There were four (4) full size sheet pans sitting directly on the floor in the dish room. There was one (1) clean tray of 9 oz bowls sitting on top of the hand-washing sink in the dish room. Employees are documenting wrong sanitizer PPM on the low temperature dish machine log. Ecolab test strips indicate these four options 10 ppm, 50 ppm, 100 ppm and 200 ppm. For the month of December, they documented 150, 160, 170, 175 and 180 for every PPM that was documented. The surveyor spoke to the Registered Dietician (RD), Director of Dining, District Manager. The RD, Director of Dining and the District Manager acknowledged the deficient practice and said they would educate the staff on the proper way to test and document per their policy and procedure. On 12/17/25 at 11:42 AM observation revealed the cornstarch containers lid was not on securely and Employee #81 verified it should be and fixed the issue. On 12/17/25 at 11:48 AM the three (3) compartment sink log was not filled out for dinner ware washing on 12/16/25 or breakfast ware washing today 12/17/25. It was currently being used. Employee #152 verified that it should have been temped and the sanitizer PPM should have been documented. 12/17/25 at 12:00 PM On 12/17/25 at 12:00 PM there was no lid on the trash can in the dish room. Employee #152 stated it should be on when not in use, and he put it on.